STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure residents received adequate supervision for 1 of 7 residents (CR #1) reviewed for quality of care.CR #1 eloped from the facility on 02/23/2026 from an unwitnessed point of exit, and was located at the rear of the property at a school.The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 02/23/2026 and ended on 02/23/2026. The facility corrected the non-compliance before the investigation on 03/10/2026. The IJ template was provided to the Administrator on 03/12/2026 at 2:02pm.This failure could place the residents with exit seeking behaviors at risk for injury or death.Findings included:Record review of CR #1's undated face sheet, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. CR #1 had diagnosis of unsteadiness on his feet, vascular dementia (decline in mental abilities), urine retention (buildup of urine), infection and inflammatory reaction due to indwelling urethral catheter (bacteria or germs have entered the urinary tract through the tube causing sickness and irritation). He was discharged to the hospital.Record review of CR #1's admission assessment dated [DATE] revealed in the category of Elopement Risk Evaluation, he was not bedfast, non-ambulatory, or unable to self-propel in a wheelchair independently. CR #1 did not have history of elopement at home or had made attempts to leave the facility without informing staff. CR#1 was not seen packing belonging to go home without a discharge plan in place. CR #1 did not wander with a specific destination in mind, attempted to open secured doors, or tried to leave the facility to go home.Record review of CR #1's admission MDS assessment dated [DATE] revealed a BIMS score of 07 of 15 was indicative of severe cognitive impairment, and significantly impaired cognitive functioning. CR #1 was assessed as not exhibiting behaviors for wandering. He had impairment of the lower extremities (hip, knee, ankle, foot) and no impairment of his upper extremities (shoulder, elbow, wrist, hand). He utilized a walker and a wheelchair for mobility.Record review of CR #1's Care Plan dated 02/23/2026 revealed he was at risk for elopement as evidenced by history/attempt to leave facility. Interventions put into place included distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, assist to ambulate or wheel resident outside as needed to ease restlessness, check on resident frequently, and one-to-one monitoring until acute condition improves.Record review of CR #1's Incident Report dated 02/23/2026 at 11:01am read incident description as, CR#1 was found wandering in back of facility, unable to give description, and the incident was not witnessed. Immediate action taken by the facility read, CR #1 was redirected and brought inside, head to toe assessment and skin assessment was done and resident placed on one to one monitoring and he was not taken to the hospital. There were no injuries observed or noted and no pain. Predisposing physiological factors read impaired memory and recent change in condition. Predisposing situation factors read CR #1 used a walker and was a wander.Record review of CR#1's Progress Note dated 02/23/2026 at 11:33 am by the Administrator revealed CR #1 was going for a walk when asked what he was doing outside of the facility. CR #1 stated the door alarm did sound off when he walked out.During an interview on 03/10/2026 at 3:42 pm, the family member of CR #1 stated that CR #1 had (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dementia ,and is in very poor health. She reported that he has no prior history of elopement and believes he attempted to go outside because she had taken him out earlier in the week. She said that on 02/23/2026, the day he exited the facility, CR #1 told her he put on his own shoes, which is unusual for him. She explained that after she arrived at the facility and learned of the elopement, his condition deteriorated within a few hours, prompting staff to call an ambulance. The hospital later confirmed that CR #1 had a urinary tract infection.During an interview on 03/11/2026 at 12:15pm, LVN M stated she was not aware that CR #1 had eloped until the unit manager informed her that the resident returned to the building. LVN M completed a head-to-toe assessment and checked the resident for injury and pain. At the time of the assessment, LVN M observed that CR #1 was agitated and appeared confused, and based on her previous interactions with him, he was not himself. LVN M reported that she completed an SBAR for change in condition and notified the nurse practitioner, who ordered a urine sample, and blood work. She stated the last elopement training occurred on 02/23/2026, which included information on residents who wandered or exhibited exit-seeking behaviors. She explained that the facility maintains pictures of all residents at risk for wandering or elopement at the nurse's station. She stated the protocol for elopement requires staff to respond to exit door alarms by immediately checking on their residents and ensure all individuals are accounted for before the alarm is turned off. The risk of elopement is the potential for resident harm by becoming lost or being struck by a vehicle.During an interview with the SW on 03/11/2026 at 1:13pm, she stated she did not witness CR #1's elopement but did confirm seeing him earlier that day in passing. She reported that she was informed of the elopement after leaving a meeting and subsequently conducted a BIMS assessment. She stated the resident had demonstrated severely impaired cognition from admission to the present, with his score deceasing from 9 to 7 on the day of the incident. She stated during her assessment, he did not exhibit any noticeable changes in his behavior. She explained that the protocol when a resident attempts to leave the facility is to notify the administrator, nursing staff, and the family to ensure all residents can be accounted for.During an interview with LVN O on 03/11/2026 at 2:47pm stated she witnessed CR #1 attempt to leave the facility earlier in the day at the 100-hall exit. She observed the resident using his walker to push on the exit door, which triggered the alarm. LVN O stated the other staff members redirected him away from the door, but she was unsure where he was taken afterward. She stated she could not confirm whether an assessment was completed following this initial wandering attempt. LVN O stated she was later notified by a phone call from the Administrator that CR #1 had successfully eloped from the facility, and had been found on the school property connected to the facility grounds. She stated that the protocol for residents who were wandering or attempting to elope, is to conduct an immediate assessment, and ensure the resident's picture is posted at each nurse's station. She stated the resident is then to be placed on one-to-one Supervision by facility staff. LVN O also stated she did not inform the DON after witnessing CR #1's first attempt to leave the facility, but wishes she had, so that all parties could have been more involved.During an interview with the DON on 03/11/2026 at 3:26pm stated she reported that staff informed her CR #1 went to the exit door, but was redirected back to his room, which was located near the door. She stated redirection involved engaging the resident, and that its effectiveness depends on the resident's cognitive status. The DON stated the facility's wandering and elopement policy is once a resident is identified as wandering, staff should notify management, complete a reassessment, and add the resident to the elopement program. She stated that the initial redirection attempt was brought to her attention during the investigation. The DON stated she learned during the investigation the facility received a call from a nearby school reporting a resident on their property, who was found to be CR #1. She stated the teacher that observed CR #1 on the school playground appeared disoriented. The DON stated she observed the resident once he returned to the facility with the assistance of the Administrator and facility receptionist. She stated CR #1 was assessed from head to toe and appeared to be tired but was talking and did not appear to be confused. The DON stated CR #1 told her he went outside when the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alarm sounded, and said he was trying to go home. She stated the staff are trained to immediately report elopement incidents, notify the DON, and implement one-to-one supervision. She stated she would have assessed the resident, determined his intent, and ensured close supervision. The DON stated that no staff admitted to turning off the exit door alarm, the alarms were checked, and she believed the alarm may have been manually turned off by unknown staff.This was determined to be a Past Non-Compliance Immediate Jeopardy on 03/12/2026 at 1:45pm. The Administrator and the DON were notified on 03/12/2026 at 2pm. The Administrator was provided with the IJ Template on 03/12/2026 at 2:02pm. The facility took the following action to correct the non-compliance prior to the investigation:Record review of CR #1's Elopement Risk Evaluation dated 02/23/2026 at 12:10pm revealed a score of 1, indicating CR#1 was a high risk of elopement and action items must be implemented to include, alert Administrator and DON immediately, obtain resident photo and place in elopement prevention system, place on 1:1 monitoring until alternate setting is located and resident is transferred, and implement or update element risk care plan.Record review of facility's Ad Hoc QAPI meeting dated 02/23/2026 at 3:30pm revealed CR #1 was placed on one-to-one supervision with nursing staff, with additional support from family. Facility staff received education on elopement prevention. Laboratory tests were ordered for CR #1, and care plans for residents identified as risk for elopement were reviewed.Record review of CR #1's Physician Order dated 02/23/2026 reflected culture, urine uncollected 5:28pm by LVN M.Record review of the Elopement Audit revealed there were no residents at risk for wandering or elopement.Record review of In-Service Education dated 02/23/2026 for Elopement, Abuse and Neglect, and Behaviors for all and signed by 59 staff members. A brief outline of the in-service included, defining elopement and wandering per CMS guidelines, identifying risk factors, identify strategies and tools for prevention, identifying person-centered interventions to prevent unsafe wandering and elopement, and identify the appropriate response for a missing resident. Staff were also in-service on abuse, neglect, and exploitation which included the welfare and rights of each resident developed and implemented for prevention of the allegation.Record review of Fire Equipment Invoice dated 02/24/2026 revealed reprogramming of all exit door keypads was completed, and the fire exit inspection and tamper switch reset were also performed.Record review of the facility's policy and procedures on Elopements and Wandering revised on 12/01/2025 read in part: Policy:This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless.Monitoring and Managing Residents at Risk for Elopement or Unsafe WanderingResidents will be assessed for risk of elopement and unsafe wandering upon admission, readmission, quarterly, and upon change of condition throughout their stay by the interdisciplinary care plan team.During an interview with CNA R on 03/12/2026 at 7:15am stated she reported she was not working the day CR #1 eloped. She stated that residents identified as being at risk for elopement have photographs posted at the nurses' station, and this information was also communicated through reports, or by the charge nurse. CNA R stated the residents may also be assigned a sitter if needed. She stated the elopement protocol as keeping the resident within staff line of sight. She stated she never personally experienced an elopement, and reported that it has not occurred on her shift, to her knowledge. She stated the most recent elopement in-service occurred approximately two weeks prior. However, she was unable to clearly recall the specific procedures. She stated that if a resident is found to be missing, staff are to notify the charge nurse and alert other staff members. She stated that residents cannot exit the building without triggering an alarm. She stated if an alarm sounded, she would respond to investigating the situation. She stated if a resident attempted to leave the building, she would notify the charge nurse and attempt to distract the resident from exiting further but would not physically restrain the resident. She stated she accounts for residents by completing rounds at the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	beginning of her shift, and conducting rounds at least every two hours, or more frequently, for residents with increased care needs. She identified the risks associated with elopement as potential kidnapping, falls, and sustaining injuries.During an interview with the Maintenance Director on 03/12/2026 at 7:25am stated that when CR #1 eloped, he checked all exit doors throughout the facility to confirm the alarms were sounding. The Maintenance Director stated alarms may be silenced using a key or keypad code by the Administrator, DON, Unit Manager, ADON, and himself. However, it could only occur after staff verified all residents are safe. Each nurse's station is equipped with a keypad system that illuminates to indicate which exit door has been opened and where the alarm is sounding. The Maintenance Director stated the potential risks associated with elopement included injury or death. During an interview with LVN S on 03/12/2026 at 7:33am stated she was not working at the time CR #1 eloped. She stated the most recent elopement inˆservice occurred approximately two weeks prior. She stated that residents at risk for wandering or elopement were identified by the interdisciplinary team, which informs staff and updates the resident's care plan accordingly. She stated her role consists of completing angel rounds only. She stated the elopement protocol as initiating a text message alert to staff. She stated staff on the unit are notified, a code is announced, and staff respond by checking resident rooms, obtaining a census sheet, and ensuring all residents are accounted for within the building. She stated if a resident attempts to leave the building, she stated she would attempt to redirect the resident through verbal interaction, walk with the resident, and request assistance from an aide. She reported that if an exit door alarm sounded, she would immediately respond to the door that is activating. She identified the risks associated with elopement as the resident being injured by landscaping or bushes, entering the street and being struck by a vehicle, or falling and sustaining injury.During an interview with LVN T on 03/12/2026 at 7:42am stated she was not present at the time CR #1 eloped. She stated the most recent elopement inˆservice occurred approximately two weeks prior. She stated that if a resident was not observed, she would immediately alert management and staff to initiate a roomˆtoˆroom search. She stated if the resident is not located within the building, staff would expand the search to the exterior grounds. She stated that no formal code is announced; instead, staff verbally inform one another. She stated that once the resident is located, an assessment is completed, and the resident's photograph is posted at each nurse's station as well as at the front of the facility. She stated if a resident attempts to leave the building, she would attempt to redirect the resident to their room or the nurses' station and notify both the physician and management. She stated if the resident was not previously identified as being at risk for elopement, she would complete an SBAR. She identified changes in condition as exitˆseeking behaviors, pacing, and entering other residents' rooms. She stated if an exit alarm sounded, she would check the alarm panel to identify which door was activated and determine whether anyone exited the building. LVN T stated she would notify maintenance and management to deactivate the alarm once all residents have been accounted for. She stated that residents are accounted for using the census and through rounds conducted at the beginning of her shift and continuous throughout the day. She identified the risks associated with elopement as significant danger due to a nearby pond and roadway, placing residents at risk of becoming lost or being struck by a vehicle.During an interview with the Administrator on 03/12/2026 at 9:57am, she reported that central supply received a call at the front desk regarding the CR#1. The Administrator stated she located CR #1 at the edge of the parking lot near the school and returned him to the facility in a wheelchair. She stated upon returning to his room, the resident's family member was present. The Administrator stated CR #1 stated he had gone for a walk and reported no injuries or falls while using his walker for assistance. She stated a skin assessment was completed with no injuries noted, and laboratory work was ordered. She stated CR #1 was placed on one-to-one supervision by staff or family and if the family were not available, they would need to inform her immediately to ensure he is accompanied by staff. She stated as part of QAPI, the facility conducted in-service training on abuse, neglect, and elopement and reviewed residents for potential elopement risk. The Administrator stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she was not aware of the resident's initial elopement attempt, but believed when CR #1 successfully eloped from the facility he went out the exit door on the 100 hall. The Administrator reported CR #1 was outside of the facility for approximately 12 minutes.During an interview with LVN P on 03/12/2026 at 3:03pm stated she was not working the day CR #1 eloped, but her most recent elopement in-service occurred approximately two weeks ago. She stated residents identified as being at risk of wandering or elopement were verified through photographs posted at each unit nurses' station. She stated the facility's elopement protocol requires staff to immediately alert other staff and notify the administrator. She stated staff are to first attempt to locate the resident as quickly as possible. She stated if a resident attempted to leave, staff would redirect the resident back to their room, offer snacks a calming intervention, implement one-to-one supervision, complete an assessment, and notify all appropriate parties. She stated when an exit alarm sounds, staff are to locate the exit door and determine who exited the area. She stated she accounts for her residents by conducting counts and performing rounds at least two hours, with additional rounds as needed. She stated the identified risks associated with elopement include the resident becoming lost or sustaining injury.During an interview with CNA N on 03/12/2026 at 3:16pm stated she was present on the day CR #1 eloped. She stated her office was located near the 100 hall. She stated she observed CR #1 push open the exit door, which activated the alarm. She stated she redirected him to his room, where he sat in a chair for approximately two to three minutes. At that time, he did not appear agitated or confused and appeared curious about the outside area. She stated when CR #1 successfully eloped from the facility, she was in the dining room assisting with resident trays for lunch. She stated the most recent elopement training occurred approximately two weeks prior. She stated the elopement protocol is to notify the Administrator and DON, search the facility both inside and outside, and contact 911 if the resident is not located. She stated the risks of elopement as falling, particularly due to ponds located behind the facility, and the possibility of the resident not being found.During an interview with CNA Q on 03/12/2026 at 3:29pm stated she was not working the day CR #1 eloped. She stated her most recent elopement inˆservice occurred at the end of the previous month. She stated that when an elopement occurs, staff were required to notify the administrator and Director of Nursing, conduct a search of the facility both inside and outside, and contact law enforcement if the resident is not located. She stated if a resident attempts to leave the facility, staff are to notify appropriate personnel and attempt redirection through verbal engagement. She stated she would walk with the resident and would not leave them unattended, and that management would assign one to one supervision until the resident is deemed safe and all required assessments are completed. She stated if an exit alarm sounded, she would respond to the door, initiate a search, and account for all residents. She stated she accounts for residents through frequent rounds. She stated the risks associated with elopement as being struck by a vehicle or potential harm from wildlife due to the wooded area surrounding the facility.An observation was conducted on 03/11/2026 at 3:49pm with the Maintenance and DON to verify that all exit door alarms were functioning properly and activated when tested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to carry out activities of daily living necessary services to maintain grooming and personal hygiene reviewed for 2 of 7 residents (Resident #34 and Resident #123).The facility failed to ensure Resident #34 and Resident #123 received scheduled showers/bathing as required.This failure could result in skin breakdown, decreased self-esteem and quality of life.Findings included:Record review of Resident #34's undated face sheet revealed a [AGE] year-old female who was admitted on [DATE]. Her diagnosis was fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing (healing fracture of right hip), falls, and muscle weakness.Record review of Resident #34's admission MDS assessment dated [DATE] revealed her BIMS score of 10 out of 15 indicated moderate cognitive impairment. Functional Abilities for Shower/bath and toileting hygiene revealed she required partial/ moderate assistance from staff to help lift, hold, and support.Record review of Resident #34's Care Plan dated 02/28/2026 revealed she required assistance of 1 or 2 staff to move between surfaces. This may fluctuate with weakness, fatigue, or weight bearing status. There were no additional interventions regarding bathing or ADL deficit.Record review of Resident #34's Progress Notes dated 02/28/2026 to 03/13/2026 revealed no documentation of refused showers.Record review of Resident #34's Kardex initiated on 02/28/2026 revealed a bathing schedule of every day, any time of the day with a CNA. Check marks were entered under the Not Applicable column for shower/bath/bed bath from 02/28/2026 through 03/06/2026.Record review of Resident #34's Bathing Documentation revealed:02/28/2026-03/06/2026 Not ApplicableDuring an interview on 03/10/2026 with Resident #34 at 12:55pm, she reported she had one shower since being admitted into the facility on [DATE]. She stated that she tries not to feel some way about not having a shower because she knows the staff were too busy with other residents when she asks for assistance with bathing.2. Record review of Resident #123's undated face sheet revealed a [AGE] year-old female who was admitted on [DATE]. Her diagnosis are displaced fracture of lower end of right humerus, subsequent encounter for fracture with routine healing (healing fracture of the right elbow/upper arm), depression, and anxiety.Record review of Resident #123's admission MDS assessment dated [DATE] revealed her BIMS score of 12 out of 15 indicated noticeable memory and thinking difficulties. Functional Abilities for Shower/bathe self and toileting revealed she required substantial/maximal assistance from staff to help lift, hold, and support.Record review of Resident #123's Care Plan dated 03/07/2026 revealed she had limited physical mobility with no interventions, and she had an ADL self-care performance deficit and there were no interventions listed.Record review of Resident #123's undated Kardex revealed no specifications for ADL- bathing.Record review of Resident #123's Bathing Documentation revealed:03/06/2026 at 8:02 pm shower by CNA W03/07/2026 at 12:28 pm bed bath by CNA X ; 9:03 pm shower by CNA Y.03/08/2026 at 5:17 pm shower by CNA XNo checkmarks for 03/09, 03/10, 03/11, and 03/12.Record review of Resident #123's Progress Notes dated 03/06/2026 to 03/13/2026 did not reveal documentation of refused showers.Record review on 03/13/2026 of Shower Sheets for all halls revealed no documentation of showers or baths for Resident #34 and Resident #123 from 02/25/2026 through the date of review. An interview and observation on 03/10/2026 with Resident #123 revealed she hasn't had a shower since being admitted into the facility, and it makes her feel nasty. Resident #123's hair was observed to be extremely oily. She stated that she is supposed to get a shower that day, but it has not been confirmed yet and doesn't want the staff to feel that she is asking for too much when it's also other residents in the building.An interview on 03/13/2026 at 2:50 pm with CNA U stated she did not recall bathing Resident #34. She stated no one has access to her log in besides her. She stated that she is temporary staff, and she verifies when a resident needs a shower by the schedule on the nurse's desk. It is the resident's choice if they want to shower, and it is encouraged. The risk of showers not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being provided as scheduled could result in distress and decreased quality of life.During an interview on 03/13/2026 at 3:11 pm, CNA V stated, upon reporting to work, she checked on residents and asks whether they would like to receive a shower. She reported that showers may be provided daily. However, the facility follows a schedule in which residents on the odd side of the building receive showers on Mondays, Wednesdays, and Fridays, and residents on the even side receive showers on Tuesdays, Thursdays, and Saturdays. CNA V indicated she was familiar with Resident #123 and stated she would not have documented a shower in the electronic health record unless she personally provided the shower and no one has access to her login information for the electronic health record. She identified the risk of showers not being received would cause potential frustration, also stating that residents have the right to accept or refuse bathing care.During an interview on 03/13/2026 at 3:38 pm, CNA X stated that residents received showers based on a scheduled rotation, with residents on the even side of the building scheduled for showers on Mondays, Wednesdays, and Fridays, and residents on the odd side scheduled for Tuesdays, Thursdays, and Saturdays. She reported that she is not assigned to a specific hallway, and shower assignments are pre-determined and documented in a shower book, which has been in use since she begun employment. She stated that completed or refused showers are documented in the electronic health record by checking the appropriate entry. CNA X reported that she worked with Resident #34. However, she does not recall providing a shower to the resident on 03/01/2026, and does not believe the resident was on her assigned shower list. She further stated that she is not scheduled to provide showers for Resident #123. She confirmed that no one has access to her PCC login information other than herself. She identified the risk of showers not being received would cause an increased risk of infection, including bacterial infection.During an interview on 03/13/2026 at 4:07 pm, the DON stated following attendance at training, she implemented the use of shower sheets after corporate provided clarification of purpose. She reported that staff should not use the electronic health record and shower sheets as documentation methods, and shower sheets are intended to be the sole method of documenting showers. She explained that the shower sheets are used to identify and verify any skin concerns observed during bathing. The DON reported that she is not familiar with the facility's shower/bathing policy. She stated residents should receive showers as often as they desire. However, the facility follows a schedule in which residents are typically provided with showers three times per week. To ensure showers are being completed, the DON stated she relies on observation and communication, including noting whether residents have fresh linens, appear groomed (such as shaved), and verbally report having received a shower. She reported that she has not audited the shower sheets, and unit managers are responsible for auditing them, with nursing staff expected to review and sign off. The DON identified the risks of showers not being received would cause a bacterial buildup, skin breakdown, and unpleasant odors.During an interview on 03/13/2026 at 5:10 pm, CNA W stated that she identified residents who required showers by reviewing the shower book, which outlined the schedule as Mondays, Wednesdays, and Fridays for residents on the odd-numbered side of the building and Tuesdays, Thursdays, and Saturdays for residents on the even-numbered side. She reported that shower assignments are determined by the scheduler who posts a schedule identifying the rooms assigned to each staff member and the designated shower days for residents. She stated that when a shower is refused, she would notify the nurse. She used paper shower sheets to document showers and informed the nurse if she is unable to provide a scheduled shower. She reported that she does not routinely document completed showers herself, as nursing staff review and verify the showers afterward. Regarding Resident #134, she stated that she does not recall providing the resident with a shower on the date in question and indicated that she would have documented the shower in the electronic health record had she provided it. She identified the risks of showers not being received would cause a skin breakdown and other related concerns, and stated without regular bathing, changes in skin condition may go unnoticed.Record review of facility policy for Activities of Daily Living implemented on 12/01/2025 read.Policy:The facility will, based on the resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.Care and services will be provided for the following activities of daily living:Bathing, dressing, grooming and oral care;Transfer and ambulation;Toileting;Eating to include meals and snacks; andUsing speech, language or other functional communication systems.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for 1 of 5 residents (Resident #40 and Resident #68) and one of three medication carts (300 hall nurse cart) reviewed for storage of medications.1. The facility failed to keep Resident #40's medications secured. Eight unidentified medication tablets were found in a medication cup inside Resident #40's mini refrigerator. Resident #40 did not have orders to self-administer medications.2. The facility failed to keep Resident #68's medications secured. One albuterol solution was found in the resident's purse. Resident #68 did not have orders to self-administer medications.3. An unlocked and unattended medication cart was observed in a hallway in front of a resident room.The deficient practice could place residents at risk of not receiving the therapeutic benefit of medications, infection, drug diversion or ingestion of unprescribed medications to residents, staff, and visitorsFindings included:Record review of Resident #40's face sheet dated 03/11/26 revealed a [AGE] year-old admitted to the facility on [DATE]. His diagnoses included Parkinson's disease (a nervous system disorder), Diabetes (a chronic condition that occurs when blood glucose levels are too high), falls, hypertension (elevated blood pressures), Dementia (a general term for a group of symptoms that cause a loss of cognitive functioning) and depression.Record review of Resident #40's annual MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition. Resident #40 required set up assistance for all ADLs and he used a wheelchair for mobility.Record review of Resident #40's undated care plan (downloaded on 3/11/26 at 10:10 AM) included: Focus - Resident #40 had behavior problems AEB: keeps medications at bedside, non-compliant with education on walking with stand by assistance with use of walker, uses another resident's walker without assistance r/t dementia, Parkinson's. Date initiated 02/10/25, revised on 03/10/26. Goal - Resident #40 will have fewer episodes of behaviors, revised on 02/05/26. Interventions included - Explain all procedures to the resident before starting and allow the resident to adjust to changes, revised on 12/10/25. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, revised on 12/10/25. Focus - Resident #40 was resistive to care refusing medications just don't want to take them, date initiated 06/10/25, revised on 07/24/25. Goal - Resident #40 will cooperate with care through next review date, revised on 02/05/26. Interventions included - Educate resident/family/caregivers of the possible outcome (s) of not complying with treatment of care, revised on 06/10/25. The resident's triggers for resisting care are (not liking the way he feels). The resident's behavior is de-escalating by (one on one) (follow up with psychologist noted), revised on 06/10/25. Further review revealed no care plan for self-administration.Record review of Resident #40's active physician orders as of 03/11/26 revealed the following scheduled medications in whole tablet form: Amlodipine 5mg tablet daily for HTN, Atenolol 50mg tablet daily for HTN, Cyclobenzaprine 5mg tablet for muscle spasms, Eliquis 5mg tablet BID for stroke prevention, Famotidine 20mg tablet BID for vitamin deficiency, Gabapentin 600mg tablet at bedtime for diabetic neuropathy, Jardiance 25mg tablet daily for diabetes, Lisinopril 40mg tablet daily for HTN, Memantine HCL 10mg tablet BID for dementia, Methimazole 5mg tablet daily for hypothyroidism, Mirabegron ER 25mg tablet daily for bladder spasms, and Tylenol 325 mg 2 tablets in the morning for pain. Further review revealed there was no order for self-administration of medications. Record review of Resident #68's undated face sheet revealed an [AGE] year-old female who admitted into the facility on [DATE]. She had diagnoses of paroxysmal atrial fibrillation (heartbeat that suddenly starts and stops on its own), obesity, kidney disease, diabetes, and epilepsy. There was no diagnosis related to the use of albuterol (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sulfate.Record review of Resident #68's admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition. There were no behaviors identified and the use of a walker and wheelchair for mobility devices to assist with walking. There are no impairments for upper and lower extremities.Record review of Resident #68's active physician orders as of 03/13/2026 revealed the following scheduled medications for inhalation form: Arformoterol Tartrate Inhalation Nebulization Solution 15 MCG/2ML for congestive heart failure, and Budesonide Suspension 0.5 MG/2ML for congestive heart failure.In an interview and observation on 03/10/2026 at 10:53am, Resident #68 stated she was using oxygen at night for the diagnoses of congestive heart failure and emphysema. This surveyor observed Resident #68's beige purse on her lap, open, revealed Albuterol Sulfate 90 mcg. Resident #68 stated that she uses Albuterol Sulfate when she is wheezing or coughing and the staff is aware she has it.Observation and interview on 03/10/26 at 11:30 AM, Resident #40 was awake, alert and lying on his left side on the bed. Surveyor asked permission to look in the refrigerator and freezer to check thermometer temperatures. Resident #40 stated, go ahead. Inside the mini-refrigerator door compartment was a clear plastic 30ml medication cup with 8 pills of various shape and size: 2 large round white tablets, one oblong pale-yellow tablet, one medium sized round pale-yellow tablet, one medium sized round white tablet, one small round tablet, one small round yellow tablet and one pink tablet. When asked about the pills, Resident #40 stated he would take them later. In an interview on 03/10/26 at 11:45 AM, LVN F stated she was assigned to Resident #40, and said the Medication Aides administered most of the oral pills, and she did not know why or who would have put the medications in the refrigerator. LVN F stated the medications should not be in the fridge and expected medication aides to watch and make sure Resident #40 swallowed medications when given. LVN F then entered Resident #40's room. Resident #40 was heard yelling at LVN F. LVN F exited the room and stated Resident #40 grabbed the medication cup, told her he would take them later then cursed at her.In an interview on 03/11/26 at 12:00 PM, MA J stated she had not worked with Resident #40 in a while and would never leave medications with a resident.In an interview on 03/11/26 at 12:20 PM, MA G stated she was familiar with Resident #40 and would always make sure he swallowed his medications in front of her and would never leave a medication cup with pills in his room. MA G stated it was important not to have medications in the fridge because other residents might enter their room, find them and ingest medications that did not belong to them.In an interview and observation on 03/11/26 at 2:10PM, the Regional Corporate Nurse stated the facility conducted an investigation into the medications that were found in Resident #40's refrigerator. Resident #40 was unable to state why they were there, where they came from, or the length of their stay. The Regional Corporate Nurse stated that Resident #40's family members visited and that the medications could have originated from the family. The Regional Corporate Nurse and MA G assisted in trying to identify the pills from the photo taken by the Surveyor comparing them to Resident #40's medications stored in the medication cart. MA G stated the 2 large white pills were 325mg Tylenol, the small pink tablet was a multivitamin, and the oblong pale-yellow tablet was Jardiance. The remaining tablets could not be identified.In an interview on 03/11/26 at 2:20 PM, the DON stated she expected the staff to watch the resident consume the medication when passing medications to residents. The DON stated the medications should not be left for residents to self-administer and residents should not be holding on to medications given to them. In an interview on 03/11/26 at 4:40 PM, MA H stated she worked the 2:00 PM to 10:00PM shift, and was familiar with Resident #40. MA H stated Resident #40 did not have a lot of medications to give on her shift, and would refuse the 6:00 AM medications because of the time. MA H stated she would return at Resident #40's preferred time after breakfast at 9:00 AM when he would accept the medications. MA H stated she would never leave medications with Resident #40 and walk away. MA H stated the risk for Resident #40 was that he could choke on the medications and no one would be around to help him. MA H stated it was facility procedure to always watch the residents consume the medications before walking away.In an interview on 03/11/26 at 4:45 PM, MA I worked the 2:00 PM to 10:00 PM shift, and stated Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#40 always refused his medications. MA I stated she would try again and return when Resident #40 was in the right mood, then he would accept the medications. MA I stated she always watched to make sure Resident #40 swallowed the medications. MA I stated she would never leave medications with Resident #40 for him to take later. MA I stated the risks would be that he would forget to take them, missing a dose and the timing of the medications would be off schedule. MA I stated she received in-services on medication administration yearly and several times in between.Observation on 03/13/2026 at 2:03 p.m. revealed an unlocked/unattended medication cart in front of room [ROOM NUMBER] on [NAME] Lane. The cart was facing outward, with the drawers accessible to passersby. One staff member was observed cleaning the carpet in a room across the hall. At the time of the initial observation, he was the only person within sight of the cart. During the 8-minute observation, several staff and one unidentified resident walked past the cart. None of the staff appeared to look at the cart. Continuous observation revealed several times no staff were within line of sight of the cart. A second Surveyor stood next to the cart for several minutes. The second Surveyor then left to find the nurse.Continued observation at 2:13 p.m. revealed LVN L was walking in the hallway. The Surveyor asked LVN L if she knew who was responsible for the medication cart. She said it was the nurse's cart. LVN L then locked the cart. Continued observation at 2:20 p.m. revealed LVN K arrived at the cart. When the surveyor informed her the cart was unlocked, LVN K replied, It's habit. She said anyone could have gotten into the cart and taken the medications. She said the narcotics were locked in a separate compartment. In an interview on 03/13/2026 at 2:35 p.m., the DON said if the cart was in within view of the nurse, it did not need to be locked. If the nurse is unable to see the cart, it would need to be locked. She said if a cart was unlocked, a resident or someone else could ?go inside the cart.' She said if a resident got meds it would be possible for them to have an allergic reaction or could cause harm. She said LVN K had been called away from the cart by a surveyor. The DON was informed that the surveyor she was referring to had also stood by the unlocked/unattended medication cart for several minutes.Observation on 03/13/2026 at 2:46 p.m. revealed LVN K at the same medication cart. Observation of the contents revealed medication bubble packs, nebulizer treatments, and other prescription medications as well as over the counter medications and supplements. She said the cart was for the 300 and 400 halls.In an interview on 03/13/2026 at 4:25 pm, the DON stated , for emergency purposes, no residents are permitted to keep medications for self-administration. All medications are expected to be stored in the designated areas, with medications carts and the medication room always secured. Failure to do so poses a risk of potential harm to residents if they gain access to the medications.In an interview on 03/13/2026 at 6:15 p.m., the Administrator said medication carts should be locked if unattended. She said if a resident accessed the medications, it could cause injury.Record review of the facility's policy for medication storage dated 12/01/25 read in part: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper . security.1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents who require dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 1 resident (Resident # 124) reviewed for quality of care. The facility failed to ensure Resident #124's transportation arrangements were made for a dialysis (a medical procedure used to remove waste products and excess fluid from the blood when the kidneys are not functioning properly) appointment as physician ordered. Resident #124 missed a dialysis treatment on 3/10/26.This failure could affect residents who received transportation services for appointments, and place them at risk of complications and not receiving proper care and treatment to meet their needs. Findings included:Record review of Resident #124's face sheet dated 03/12/26 revealed she was admitted to the facility from the hospital on [DATE]. Her diagnoses included acute osteomyelitis of the right ankle and foot (an infection of the bone that develops quickly), liver disease, acute kidney failure (an abrupt decrease in kidney function), heart failure, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), Diabetes (a chronic condition that occurs when blood glucose levels are too high), acquired absence of right great toe, and hypertension (elevated blood pressure).Record review of Resident #124's admission MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition. She required substantial assistance with showering and dressing. She required partial assistance with toileting. She required set-up assistance with eating and personal hygiene. She used a wheelchair for mobility. She was always continent of bowel and bladder. Resident #124 had functional limitations to one side of the upper extremity and had impairment to both sides of the lower extremities.Record review of Resident #124's undated care plan report revealed: Focus - Resident #124 needed dialysis - Planning to be temporary. Goal - The resident will have no s/sx of complications from dialysis through the review date. Interventions included: Encourage resident to go for scheduled dialysis appointments, monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report PRN new/worsening peripheral edema.Record review of Resident #124's active physician orders revealed an order for dialysis at the outpatient clinic every Tuesday, Thursday and Saturday. Dialysis will start on Tuesday 03/10/26 at 3:30PM. The order was dated 03/07/26; Record review of Resident #124's welcome letter from the dialysis center dated 03/06/26 revealed the first dialysis treatment was scheduled for Tuesday March 10 at 3:30 PM.Record review of Resident #124's general note dated 03/06/26 at 7:58 PM written by LVN A read in part: admitted to the facility from the hospital.Dialysis usually Tuesday/Thursday and Saturday but resident stated it had been switched to Monday/Wednesday/Friday for another week or two.Observation and interview on 03/12/26 at 9:30 AM, Resident #124 was sitting in a wheelchair, and visiting her family in the resident's room. Resident #124 stated she was supposed to have dialysis on Tuesday 3/10/26, but there was a transportation problem. Resident #124 stated the facility was supposed to make the transportation arrangements and was not too concerned about the mix-up with transportation. Resident #124 stated the last time she had dialysis was on Friday 03/06/26, while in hospital. Resident #124 stated currently her legs felt tight and heavy and that she had pain d/t the amputation on the right foot. Resident #124 was wearing tight-fitting leggings. She was in no respiratory distress and had no difficulty with speech. Resident #124 stated she began making urine again about 2 weeks ago. Resident #124 stated she could not complete PT yesterday (3/11/26) d/t trouble bending her legs.In an interview on 03/12/26 at 9:45 AM, LVN A stated she was assigned to Resident #124. LVN A stated she notified the NP when Resident #124 missed dialysis on 3/10/26. When asked the question, why did Resident #124 miss dialysis, LVN A replied that there was an issue with transportation and the resident's schedule had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed when she was in the hospital, so she went back to her original dialysis schedule. In an interview on 3/12/26 at 10:25 AM, the Unit Manager stated she was familiar with Resident #124 and was aware she needed dialysis. The Unit Manager stated she expected the nurse who took the order for dialysis to follow up by ordering transportation and contacting the dialysis center to confirm the appointment. The Unit Manager stated the facility provided in-house transportation as well as the use of outside transportation companies for resident appointments. The Unit Manager checked the her, and stated that it was LVN A who took the order for dialysis. The Unit Manager stated she was unaware that Resident #124 missed the dialysis appointment on 3/10/26. The Unit Manager stated when Resident #124 missed the dialysis appointment, and if she was the nurse responsible for the resident, she would have called the doctor, contacted the dialysis center to see if there were any available spots to make up the missed dialysis. The Unit Manager stated if Resident #124 had dialysis on 03/06/26, missed a scheduled dialysis on 03/10/26, and then scheduled for dialysis 03/12/26, she would have gone for at least 5 days without dialysis which could lead to anything such as the risk of fluid retention.In an interview on 3/12/26 at 10:40 AM, LVN A stated when she notified the NP that Resident #124 missed a dialysis treatment, the instructions were to monitor the resident, and the NP would be in to see the resident after dialysis on 3/12/26. LVN A stated the risks to any resident if they did not get dialysis depended on the diagnosis, maybe weight gain, and fluid retention. LVN A stated if Resident #124 did not get dialysis the risks would be SOB, CHF, aspiration and weight gain. In an interview on 3/12/26 at 10:45 AM, PTA B stated she worked with Resident #124 on 03/10/26 on balance and strengthening exercises. PTA B stated Resident #124 completed the 30-minute session and did c/o fatigue. PTA B stated Resident #124 participated in breathing exercises for core strengthening without any problems. PTA B stated she worked with Resident #124 again on 3/12/26 for the 30-minute-long session which Resident #124 completed. PTA B stated on 3/12/26 Resident #124 c/o fatigue, tightness to the right leg and pain to the right toe where she had the amputation. PTA B stated Resident #124 completed breathing exercises, did well overall and that her participation during the session was no different than the session on 3/10/26. In an interview on 03/12/26 at 10:55 AM, PTA C stated she worked with Resident #124 on 03/11/26. PTA C stated Resident #124 completed the 30-minute therapy session. PTA C stated Resident #124 was participatory with frequent rest breaks. PTA C stated Resident #124's leg was bothering her, particularly her right leg. PTA C stated she did not notice any SOB, nor did she see any other signs or symptoms that she would need to report.In an interview on 3/13/26 at 11:55 AM, Receptionist D stated she received an acknowledgment on Friday 3/06/26 that Resident #124 was arriving at the facility that day, but she did not put in the dialysis transportation because she was unsure if the resident would admit to the facility or not. She said she then got busy and forgot to arrange the dialysis transportation. She said she was notified on Tuesday 3/10/26 that Resident #124 did not make it to her dialysis appointment. She called the dialysis facility on Tuesday to arrange transportation; dialysis said that Wednesday was full, but it was ok for Resident #124 to attend dialysis on Thursday at an earlier chair time. She said she was responsible for setting up transportation and had received training. She said she would now arrange transportation regardless of whether the resident being admitted to the facility or not and she would report missed dialysis appointments to the DON or Administrator.In a telephone interview on 03/12/26 at 12:49PM, the Dialysis Nurse at the outpatient Dialysis Center stated that on Monday 3/09/26 she did not receive any phone calls from the facility to confirm Resident #124's dialysis appointment for 3/10/26 at 3:30 PM. The Dialysis Nurse stated she was unaware the resident was residing at the facility until she contacted Resident #124 directly via telephone on 03/09/26. The Dialysis Nurse stated that on 03/09/26 she spoke with the receptionist at the facility, then spoke with a nurse and learned that the facility was aware of Resident #124's appointment on 3/10/26 and was informed that transportation had been set up with an outside transportation company. The Dialysis Nurse stated she did not have the names of staff she spoke with. The Dialysis Nurse stated that on 3/11/26 when the resident did not arrive for the 3:30 PM appointment she called the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and was told Resident #124 was waiting outside for the ride. The Dialysis Nurse called Resident #124 and confirmed she was outside the facility awaiting transportation. The Dialysis Nurse contacted the outside transportation company and learned Resident #124 was not booked to be picked up for the 3/10/26 3:30 PM appointment. The Dialysis Nurse contacted a second outside transportation company that was commonly used and learned Resident #124 was also not booked for transportation. The Dialysis Nurse stated she contacted someone at the facility and was told the facility would set up the ride for Thursday's appointment. The Dialysis Nurse stated she contacted the same transportation company and booked a ride for Thursday 3/12/26 11:45 AM appointment to ensure Resident #124 would not miss the appointment then contacted Resident #124 to confirm the appointment. The Dialysis Nurse stated Resident #124 was currently on dialysis and doing fine. In an interview on 3/12/26 at 2:15 PM, the NP said Resident #124 admitted to the facility on Friday of last week (3/06/26) and was dialyzed on that day. She said she saw Resident #124 on Monday (3/10/26) and she was ok and completed therapy with no swelling. She said Resident #124 was supposed to be dialyzed on Tuesday, but she received a call from LVN A that Resident #124 missed dialysis due to transportation issues. She informed LVN A to monitor the resident for fluid overload and to call her back if there was shortness of breath or lower extremity swelling. On Wednesday, she only received a call about the resident having pain. She said she received a call from a nurse today, 3/12/26 and was informed that the resident had lower extremity swelling. The NP said she told the nurse to ensure Resident #124 went to dialysis today. The NP said the risks of not getting dialysis would be edema, weight gain, and if it was really bad, then maybe SOB. The NP said the s/sx of hyperkalemia (elevated blood potassium levels, dialysis aids in regulating potassium levels for individuals who do not have adequate kidney function) would be muscle weakness, cramps, numbness and N/V. The NP stated she would not normally check labs if someone missed dialysis but would first look for s/sx such as edema, weight gain and SOB. She said she expected the facility to follow up and arrange transportation to ensure everything was done appropriately for the residents because that is their life.In an interview on 3/13/26 at 6:00 PM, the DON said the receptionist was designated to arrange dialysis transportation. She said her understanding was that the ball was dropped on the Receptionist's end, and transportation was not arranged. She said if a dialysis appointment was missed, nursing should immediately notify the NP or MD, family, and obtain any orders; put assessment pieces in place, monitor weights, and implement fluid restrictions until the resident could get dialysis. She said Resident #124 was on fluid restriction. Record review of the facility's policy for Hemodialysis dated 10/01/2025 read in part: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis.7. The facility will assure that arrangements are made for safe transportation to and from the dialysis facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for 1 of 6 residents (Resident #100) reviewed for pharmacy services. The facility failed to account for one of Resident #100's Alprazolam 0.5 mg tablets from 3/11/26 - 3/13/26.This failure could place residents at risk for drug diversion and/or duplicate therapy.Findings included: Record review of Resident #100's face sheet dated 3/13/26 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnosis included anxiety disorder, fracture of right pubis, and depression. Record review of Resident #100's admission MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15 which indicated intact cognition. Record review of Resident #100's Medication Administration Record for March 2026 revealed Alprazolam 0.5 mg was scheduled for 1 tablet every 8 hours as needed for pain, start date 3/6/26. The medication was documented as administered one time between 3/11/26 and 3/13/26 on 3/11/26 at 1:32 p.m. Record review of Resident #100's undated Narcotic Record for Alprazolam 0.5 mg revealed there were 4 entries documented between 3/11/26 and 3/13/26. One tablet was documented as administered on 3/11/26 at 8:00 p.m., 3/12/26 at 2 p.m. and 3/12/26 at 9 p.m. On 3/12/26 at 9:00 p.m. there were 66 tablets remaining. On the next entry, dated 3/13/26 at 3 p.m. there were 65 tablets remaining with the word correction written in parenthesis and one nurse signature (LVN K). There was no explanation of what happened to the unaccounted for tablet. In an observation and interview on 3/13/26 at 3:41 p.m. of the 400-hall nurses' cart, LVN K counted Resident #100's Alprazolam tablets and said there were 65 tablets remaining. She said she was unsure what happened to the missing tablet and said someone might have forgotten to sign it out on the narcotic record. She said she was coming on to work and LVN D was getting off work. She and LVN D conducted a narcotic count during shift change around 6:15 a.m. and tried to find out what happened to the tablet at that time. She said LVN D did not sign as the second nurse on the narcotic sheet because she got busy. She said she and LVN D would try and figure out what happened when LVN D arrived for her shift that evening. She said they did not report the missing tablet at the time because they wanted to see if they could find the error before escalating the situation. In an interview on 3/13/26 at 4:48 p.m., the Regional Director of Clinical Services said he expected nursing staff to account for the narcotics. He said anytime there was a narcotic missing, nursing staff should notify the DON and Administrator, the facility would interview the nurses and if they were unable to state where the tablet was, they would conduct a further investigation. He said the oncoming nurse should not have taken the keys to the nurse cart if she knew the count was inaccurate during the shift count. He said if they took the keys, they were held responsible for the narcotics. In an interview on 3/13/26 at 4:52 p.m., the Unit Manager said when administering medications, nursing staff should read the order three times and sign before giving the medication, and ensure there were no holes in the documentation. She said nursing staff should sign as they go. She said it was important to document, especially for narcotics, because they were controlled medications. She said she was not aware of any missing tablets for Resident #100. In an interview on 3/13/26 at 5:46 p.m., the DON said nursing staff should count the narcotics to keep track of the medication, and if there were any discrepancies, staff should notify her. She said she was not informed of any narcotic discrepancies by the night nurse (LVN D), and the night nurse administered the medication (to Resident #100), but did not sign it. She said staff were trained on controlled substances and were educated in school. She said the risk of an inaccurate narcotic counts could be that the residents may not receive their medication.In an interview on 3/13/26 at 6:51 p.m., LVN D said she and LVN K counted the narcotics this morning and compared each narcotic to the name and number in the narcotic book. She said, during shift change, they thought there were 66 Alprazolam (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablets for Resident #100, but that was an error. She said she thought the count was correct, and was notified later by LVN K that the count was off and needed to be corrected. She said she was unsure if anyone else was notified at that time. She said if the count was off nursing staff normally notified the DON and checked with the nurses. She said she did not notice any discrepancy with the Alprazolam until today and did not notice a discrepancy yesterday when she arrived at work. She said she was trained on controlled substances which included counting each narcotic before and after the shift and reporting any discrepancies. In an interview on 3/13/26 at 7:02 p.m., LVN K said she did some digging (research) and saw where she administered one Alprazolam 0.5 mg to Resident #100 on 3/11/26 (but did not document it on the narcotic sheet). She said there was no discrepancy of count noted on 3/11/26 after her shift. She said her main focus was documenting the administration on the computer, but she should document in the computer, and also turn to the right to document in the narcotic book, to ensure accuracy. She said if the administration was not documented in the narcotic book, it would throw the count off and confuse the other nurses.Record review of the facility's Medication Storage policy dated 12/1/25 read in part, .2. Narcotics and Controlled Substances. c. any discrepancies which cannot be resolved must be reported immediately as follows: i. Notify the DON, charge nurse, or designee and the pharmacy; ii. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted; iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators. d. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies. Record review of the facility's Medication Administration policy revised on 12/1/25 read in part, .20. If medication is a controlled substance, sign narcotic book.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7%, based on 2 errors out of 27 opportunities, which involved 1 of 6 residents (Resident #48) and 1 of 5 staff (MA G) reviewed for medication administration.MA G administered two anti-hypertensives, Amlodipine and Lisinopril, (medications that reduce blood pressure) to Resident #48 without checking her blood pressure according to MD orders, the pharmacy label, and facility policy on 3/11/26. This failure could place residents at risk of low blood pressure and hospitalization. Findings include:Record review of Resident #48's admission record dated 3/11/26 revealed an [AGE] year-old female who admitted on [DATE]. Her diagnoses included hypertension (high blood pressure), Alzheimer's disease, kidney failure, and hypertensive heart disease without heart failure (a condition caused by prolonged high blood pressure, leading to damage to the heart).Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 out of 15 which indicated severe cognitive impairment. She required set-up or clean-up assistance from staff with ADL care.Record review of Resident #48's care plan revealed she had hypertension related to hypertensive heart disease, revised on 7/21/25. Interventions were to give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure when standing up) and increased heart rate and effectiveness. Record review of Resident #48's Order Summary Report revealed orders for:Lisinopril 20 mg give 1 tablet orally one time a day for hypertension hold for SBP <110 or DBP < 60, order date 2/9/26;Amlodipine 5 mg give 1 tablet orally one time a day for hypertension hold for SBP < 110, pulse <60, order date 10/29/25.An observation and interview on 3/11/26 at 8:03 a.m., during medication pass, revealed MA G prepared Resident #48's medication for administration. She prepared Amlodipine 5 mg, Lisinopril 20 mg, Anastrozole 1 mg, Vitamin D 5000 IU, and Memantine 5 mg. The pharmacy labels for Amlodipine and Lisinopril read .Check patient's parameters before administering. MA G entered Resident #48's room and administered all medications to Resident #48 without taking her blood pressure. MA G said she did not take Resident #48's blood pressure because the eMAR did not have a heart symbol next to the medication name, which would prompt her to take the blood pressure. She said there was no prompt for her to enter the resident's vitals. She said Resident #48's blood pressure medications, Amlodipine and Lisinopril had hold orders and the pharmacy label also read to check parameters prior to administering. She said the directions had been in place, but she was new and still learning. She said if she did not check the blood pressure, the resident could go into cardiac arrest and be sent out to the hospital. An observation on 3/11/26 at 8:13 a.m. of Resident #48's eMAR revealed her last recorded blood pressure was on 3/10/26 at 9:04 p.m. Her blood pressure at that time was 123/77 with a pulse of 75. (Normal blood pressure vitals range from 90-120/60-80 and pulse range from 60-100).In an interview on 3/11/26 at 8:55 a.m. MA G said she checked on Resident #48 after the medication pass and said her blood pressure was 130/72 with a pulse of 72. In an interview on 3/11/26 at 3:09 p.m., the Unit Manager said medication aides and nurses were trained to take the blood pressure prior to administering blood pressure medications. She said when nursing staff entered blood pressure medication orders, they selected a box to include the supplementary documentation that would cause the heart symbol to pop up next to the medication. (The supplementary documentation would prompt staff to enter the residents' vitals such as blood pressure and pulse). She said there was no reason for the supplementary documentation to be deleted off Resident #48's Amlodipine and Lisinopril. She said she did change the administration time on those two medications, but did not change the supplementary documentation requirement. She said no one brought it to her attention that the supplementary documentation was not included in the orders. In an interview on 3/11/26 at 4:56 p.m., LVN F said she was unsure what MA G told her about Resident #48 earlier, but she took Resident #48's blood (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure at 8:30 a.m. and documented it.In an interview on 3/13/26 at 5:32 p.m., the DON said the blood pressure should be taken prior to administration. She said you do not want to give a blood pressure reduction medication because the blood pressure could be low and the resident could bottom out (occurs when the blood pressure has dropped to a very low level, which can reduce blood flow to vital organs) if the blood pressure was not checked. She said there were several ways that nursing staff were alerted to take the blood pressure prior to administration which included supplemental orders in the computer system. She said nursing staff were also taught in school to check the blood pressure prior to administering the blood pressure medication. She said parameter orders could also be listed in the orders. She expected nursing staff to complete their checks during medication pass which included following the instructions on the pharmacy cards and following the MD orders. Record review of Resident #48's nursing note dated 3/11/26 at 8:30 a.m. written by LVN F read in part, Patient BP 130/72 HR 72. Due medications administered as ordered by medication aide, no adverse reactions noted.Record review of the facility's Medication Administration policy revised 12/1/25 read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. Medication requiring vital signs prior to administration: .Anti-Hypertensives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly, for one out two dumpsters observed for garbage disposal.One facility dumpster lid was open and unsecured.This failure placed residents at risk of infection and a decreased quality of life due to having an exterior environment which could attract flying pests, rodents and other animals.Findings include:In an observation on 03/13/26 at 12:08 pm, the surveyor and the Dietary Manager observed the facility dumpster area, which was in the lot behind the dietary department. There were two commercial-sized dumpsters. The lid of the dumpster located on the left side was open (the dumpster was located inside a gate).In an interview on 03/13/26 at 12:09 pm with the Dietary Manager, she stated everyone (Kitchen, Nurses and Laundry) were responsible for closing the dumpster lids. She stated it should be closed after each use, but she thought it was okay for the lid to be open as long as the gate was closed (the dumpster was located inside a gate). She stated she was not sure who was the last person to use the dumpster. She stated the risk of leaving the dumpster open could be raccoons.In an interview on 03/13/26 at 6:09 pm with the Administrator, she stated the staff checked the outside dumpster throughout the day regularly, and it should have been closed. She stated dietary, maintenance and housekeeping were responsible for ensuring the dumpsters were closed. She stated the risk of the dumpster lid not being closed was pest. She stated the Dietary Manager was aware that the dumpster had to always be closed so she wasn't sure why she said it could be open if the gate was closed. Record review of the facility's Dumpster and Waste Disposal policy dated 12/01/25 reflected, 1. Prior to disposal, all waste shall be kept in a leak proof, non-absorbent, fireproof containers that are covered. 2. These containers are emptied as often as necessary throughout the day. Trash bags shall be sealed prior to removing from the facility. Trash will be deposited into the sealed container outside the premises.